PATIENT REGISTRATION AND MEDICAL HIISTORY Date:_____

First Name:_____ Last Name:_____ Birth Date:_____ Age:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Home # (_____) _____ Cell: (_____)_____ S.S. #:_____

E-mail:_____

Married ☐ Yes ☐ No Spouse's Name:_____

Employer (Self):_____ Employer (spouse):_____

Business Phone: (_____)_____ Business Phone: (_____)_____

If a minor parent or guardians name:_____ Address:_____ Phone:_____

Emergency Contact :_____ Relation:_____

INSURANCE INFORMATION

Policy Holders Name:_____

Employer:_____ Policy #_____

Date of birth:_____ S.S. #:_____

DENTAL HEALTH QUESTIONARIE

ANY ALLERGIES: ☐ Yes ☐ No If, yes please list:_____

Previuos Dentist:_____ Date: of last Visit:_____

Are you presently ill or under the care of a physician? ☐ Yes ☐ No If yes, please describe:_____

History of hospitalizations:_____

Do you require pre medication prior to dental work? ☐ Yes ☐ No

Medications presently taking (Including aspirin, etc.):_____

Do you use tobacco products? ☐ Yes ☐ No If yes, what type)_____

FEMALES:

Are you taking birth control pills? ☐ Yes ☐ No _____

Are you or might be pregnant? ☐ Yes ☐ No If yes, estimated delivery:_____

Whom may we thank for refering you?_____

MEDICAL HISTORY

Physician's Name _____ Phone #:_____ Date of Last Physical_____

Have you ever had any of the following **(please circle Y for Yes or N for No)**

☐S ☐N Headaches	☐S ☐N Epilepsy	☐S ☐N Pacemaker	☐S ☐N Swollen Neck Glands
☐S ☐N Bleeding Abnormally	☐S ☐N Autism	☐S ☐N Psychiatric Care	☐S ☐N Ulcer
☐S ☐N Blood Disease	☐S ☐N Hepatitis,Jaundice or Liver Disease	☐S ☐N Radiation Treatment	☐S ☐N Venereal Disease
☐S ☐N Cancer	☐S ☐N High Blood Pressure	☐S ☐N Recent Weight Loss	☐S ☐N Heart Murmur
☐S ☐N Chemical Dependency	☐S ☐N HIV / AIDS	☐S ☐N Respiratory Disease	☐S ☐N Heart Problems
☐S ☐N Chronic Diarrhea	☐S ☐N Low Blood Pressure	☐S ☐N Rheumatic Fever	☐S ☐N Hemophilia
☐S ☐N Circulatory Problems	☐S ☐N Mitral valve Prolapse	☐S ☐N Sinus Problems	☐S ☐N Allergies
☐S ☐N Congenital Heart Lesions	☐S ☐N Artificial Heart Valves	☐S ☐N Special Diet	☐S ☐N Arthritis
☐S ☐N Diabetes	☐S ☐N Artificial or Joints, Screws, etc	☐S ☐N Stroke	☐S ☐N Back Problems
☐S ☐N Nervous Problems			

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

Do you have any systemic disease? ☐ Yes ☐ No If so, what:_____

Have you ever taken bisphophonate? ☐ Yes ☐ No

X_____ _____

Dr's Signature Date

Have you ever responded adversely to medical or dental treament? ☐ Yes ☐ No

Are you using any recreation drougs? (marijuana, cocaine, etc) ☐ Yes ☐ No

Are you under physician care? ☐ Yes ☐ No For whay conditions?_____

Do you have any disease, condition or problem not listed above? ☐ Yes ☐ No If yes, please describe:_____

☐ Hereby acknowledge I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I further understant that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES shoul it be amended, modified or changes in any way. ☐ Patient refused / was unable to sing

☐ I have received a copy of the **DENTAL MATERIALS FACT SHEET** as required by law.

To the best of my knowledge, all of the preceding answers are true and correct. If any dhanges in my health or medications occur, I will without fail, inform the doctor at my next appointment.

I hereby request that payment of authorized benefits be made to Dental and Implant Care Center for services furnished to me. I understand that any portion unpaid by or denied by my insurance company is my responsibility and will be paid by me. I authorize the release of any information the dental benefit provider may require to determine the benefits payable. I permit a copy of this authorization to be used in place of the original.

Signature:_____ Date:_____

Patient Consent to Treatment

PATIENT NAME: _____ CHART # _____

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate. **(Initials)**_____

[ ] 1.- DRUGS, MEDICATIONS, AND ANESTHESIA:

I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, dizziness miscarriage, cardiac arrest. I understend that medications, drugs, and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four [24] hours after my release form surgery).

I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.

I understand that if I select to utilize Nitrous Oxide, "Atarax" Chidral hydrate, "Zanax", or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway anaphylactic shock, and cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sadation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours, following my dental appointment to observe for possible deleterious side effects, such as obstruction of airway. **(Initials)**_____

[ ] 2.- CHANGES IN TREATMENT PLAN:

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth and oral soft / hard tissue that were not discovered during examination (for example root canal therapy following routine restorative procedures). I give my permission to the Dentist to make any/all changes and additions as necessary, including referral to a specialist, medical doctor, or other health care professional, and the costs occurring as the consequence of this referral or any changes in the treatment plan will be my responsibility. **(Initials)** _____

[ ] 3.- HYGIENE AND PERIODONTICS (TISSUE AND BONE LOSS):

I understand that the long-term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaning regular recall visits. **(Initials)**_____

PERIODONTICS - I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction. I have been given the option to be referred to specialist as well **(Initials)**_____

[ ] 4.- REMOVAL OF TEETH:

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissues. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen in time.

Potential risks include, but are not limited to, the following:

A.- Post-operative discomfort; swelling; prolonged bleeding; tooth sensitivity to hot or cold; gum shrinkage (possibly exposing crown margins); tooth looseness; delayed healing (dry-socket) and/or infections (requiring prescriptions or additional treatment, i.e. surgery).

B.- Injury to adjacent teeth, caps, or fillings (requiring the recementation of crowns replacement of fillings, fabrication of crowns, replacement of fillings, fabication of crowns, or extraction), or injury to other tissues not within the described surgical area.

C.- Limitation of opening; stiffness of facial and/or neck muscles; change in bite; or tempromandibular joint (jaw Residual joint) difficulty (possibly requiring physical therapy or surgery).

D.- Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications.

E.- Possible bone fracture, which may require wiring or surgical treatment.

F.- Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery.

G.- Injury to the nerve underlying the teeth resulting in itching, numbness, or burning of the lip, chin, gums, cheek, teeth, and/or tongue on the operated side; this may persist for several weeks, months, or, in remote instances, permanently.

(Initials)_____

I give my consent for the doctor to perform the treatment/procedure/surgery previously explained to me, or other procedures deemed necessary or advisable as necessary to complete the planned operation.

If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever (s) he may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

(Initials)_____

[ ] 5.- FILLINGS: I have been advised of the need for fillings, either the silver or composite (tooth color), to replace tooth structure lost to decay. I understand that with time filfings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post, build-up and crowns), which would necessitate a separate charge.

I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines, although, the advantages and desadvatages have been explained to me as well as alternate materials. **(Initials)**_____

[ ] 6. **ENDODONTIC TREATMENT (ROOT CANAL THERAPY):**

The purpose and mealod of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth

I understand that treatment risks can include, but are not limited to the following:

A.- Post treatment discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.

B.- Post treatment swelling of the gum area in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.

C.- Infection.

D.- Restricted jaw opening.

E.- Breakage of root canal instruments during treatment, which may in the judgment of the doctor, be left in the treated root canal or bone as part of the filling material, or it may require surgery for removal.

F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction.

G. Risk of temporary or permanent numbness in treatment area.

If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for, and finish final root canal therapy. If root canal treatment is not finalized I expose myself to infection and/or tooth loss.If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.I understand that I may end up extracting the tooth, in such a case I will be responsible for all the costs of Root Canal , Post and Crown.

[ ] 7. **CROWN AND BRIDGE (CAPS):**

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible roots canal therapy.

I understand that like natural teeth, crowns and bridges need to be kept clean, with proper oral higiene and periodic cleanings, otherwise decay may develop undermeath and/or around the margins of the restoration, leading to further dental treatment

[ ] 8. **DENTURES - COMPLETE OR PARTIAL:**

The problems of wearing dentures have been explained to me including looseness, soreness, and possible brakage, and relining due to tissue change. Follow-up appointments are an integral part of maintenance and success of a prosthetic appliance. The doctor should immediately examine persistent sore spots.

I further understand that surgical intervention (i.e. tori [bone] removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone loss or other complicating factors, I may never be able to weardenturestomysatisfaction. **(Initials)**_____

[ ] 9. **PEDODONTICS (CHILD DENTISTRY):**

I understand that the following procedures are routinely used at DENTAL AND IMPLANT CARE CENTER, as well as being accepted procedures in the dental profession.

A.- POSITIVE REINFORCEMENT - Rewarding the child who portrays desirable behavior, by use of compliments, praise, a pat or hug, and/or token objects or toys.

B.- VOICE CONTROL - changing the tone or increasing the volume of the doctor's voice gains the attention of a disruptive child.

C.- NITROUS OXIDE AND/OR ORAL SEDATION - nitrous Oxide is a mild gas that is mixed with oxigen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use the patent/or guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent/guadian must be available to escort the child home after the sedation procedure, and observe their behavior through out the day.

I understand that with the use of an injection, used to numb the tooth area for dental procedures, the possibility exists that the child may inadvertently bite their lip causing injury to occur.

I understand the need to return to the office, for evaluation, if swelling and/or pain in my child does not go away after a sufficient period of time. **(Initials)**_____

10- **SEDATION:**

I have been informed of minor risks including but not limited to nausea, vomiting, ineffective sedation, excitement, delay recovery, incoordination, over sedation and major risks including but not limited to allergic reaction, respiratory depression. I hereby consent to the administration thereof, No Warranty or Guarantee has been made to the result of the thereof. I understand that I wil be responsible for the costs thereof.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT THE PROPOSED TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/ HER CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS.

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THE ABOVE, INCLUDING THE OPPOSING SIDE OF THIS DOCUMENT, AND CONSENT TO QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION.

I UNDERSTAND THAT DENTAL AND IMPLANT CARE CENTER PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL ABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF IT'S PATIENTS.

Signature _____ _____ _____ Relationship_____ _____ Date:_____/_____/_____

Patient or Legal Representative

Doctor:_____ _____ _____ _____ Witness:_____ _____ _____ _____

Dental and Implant Care Center

4203 Gage Ave.
Bell, CA 90201
Tel: (323) 312-0500 Fax: (323) 771-2511
E-mail: 1987dentist@gmail.com

PHYSICIAN PATIENT ARBITRATION AGREEMENT

Article 1.- Agreement Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California Law, and not by a lawsuit or resort to court process except as California Law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2 .- All claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the ocurrence giving rise to any claim.
In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages exceeding the jurisdictional limit of the small claims court againts the physician, and the physician's partners, associates, association, corporation or parthership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.
Article 3 .- Procedures and Applicable law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitration, together whit other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit.The parties agree that the arbitrators have the inmunity of judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant any other applicable statutory or common law.
Either party shall have the absolute right to arbitrate separately the issues of liabylity and damages upon written request to the neutral arbitrator.
The parties consent to the inervention and joinder in this arbitration of any persoh or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of California Law applicable to health care providers shall apply to disputes with this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or sumary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however depositions may be taken without prior approval of the neutral arbitrator.
Article 4.- General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.
Article 5.- Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.
Article 6.- **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:
Effective as of the date of first medical services

_____
Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
I undertand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____ _____
Physician's or Authorized Representative's Signature (Date)

By:_____ _____
Patient or patient Representative's Signature (Date)

By:_____
Print Patient's Name

_____ _____
Print or Stamp Name of Physician (If Representative, Print Name and Relationship to Patient)
Medical Group or Association Name

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.